

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002548  
STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. 299 Primary Registration District No. 6025 Registrar's No. 1

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Reynolds</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admittance) a. STATE <u>Missouri</u> b. COUNTY <u>Reynolds</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lesterville</u> TYP <u>Reynolds</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Oates</u> <u>Mo</u> <u>0900</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Oates</u> <u>Mo</u>		Length of stay in 1b <u>50</u> yrs	d. STREET ADDRESS <u>---</u> (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>J. Harvey</u> Middle <u>Shepard</u> Last <u></u>	4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1959</u>
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5. SEX <u>male</u> c	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2 1861</u>	9. AGE (In years (as birthday)) <u>98</u>	IF UNDER 1 YEAR Months <u>19</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	11. BIRTHPLACE (City and state or country) <u>Reynolds Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Henry Shepard</u>	13b. MOTHER'S MAIDEN NAME <u>Mahalda Reese</u>	14. NAME OF HUSBAND OR WIFE <u>Louisa Mathes</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT <u>J G Shepard</u> Address <u>Oates Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 or 8 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-Sclerosis</u>	
	DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Oates Mo</u>	COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>Jan 16</u> to <u>18</u> and last saw <u>her</u> alive on <u>Jan 20, 1959</u> Death occurred at <u>5.55</u> P <u></u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>E.M. Fitzpatrick MD.</u> (Degree or title)	22b. ADDRESS <u>Lesterville Mo</u>	22c. DATE SIGNED <u>1/24/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Myers Cem</u>	23d. LOCATION (City, town, or county) <u>Oates Mo</u>
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24. FUNERAL DIRECTOR <u>Spencer Funeral Home Inc</u>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>1/26/59</u>	26. REGISTRAR'S SIGNATURE <u>E.M. Fitzpatrick</u>
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Meyer Cemetery  
1 mi E - of Oates

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Carl H. Dwyer* .....  
Licensed Embalmer No. *2370* .....  
P. O. Address *Bellevue, VA* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.